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ABSTRACT

Historically, the literature on psychotherapy with borderline personality disorder has been based on object-relations theory or psychoanalytical approaches, rather than cognitive and behavioral approaches. In clinical assessment, the term borderline has been used to refer to patients with both neurotic and psychotic symptoms, a particular type of personality organization, or individuals who do not fit any other diagnostic category. To resolve the confusion, the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (1980) has established diagnostic criteria for borderline individuals which take into consideration the individual's long term functioning as well as periods of acute disturbance. Borderline personality disorder is characterized by limited basic assumptions, dichotomous thinking, and a weak sense of identity, all of which together form a mutually reinforcing and self-perpetuating system. Cognitive therapy with this population must be modified to allow for the difficulties borderline individuals have with relationships, goal setting, transference, and short term treatment. The therapist must strive for a calm, methodical approach, resisting the tendency to respond to each new crisis. Specific cognitive-behavioral techniques include establishing a trusting relationship, setting specific guidelines for behavior, and focusing on concrete behavioral goals. Behavioral experiments can be used to test limited assumptions and dichotomous thinking, while exploring advantages and disadvantages of various actions can aid impulsive behavior, power struggles, and fear of change. Identity building can be facilitated through feedback and identification of positive traits. Termination of therapy should always be a joint, well-reviewed decision. (BL)

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Borderline Personality Disorder:
Too Complex for Cognitive Therapy?

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ABSTRACT

Borderline Personality Disorder is apparently common, can produce significant impairment, and greatly complicates psychotherapy. However, it can be difficult to recognize and treat. While some have assumed that Borderline Personality Disorder is too complex for cognitive-behavioral approaches, recent experience suggests that a modified Cognitive Therapy approach can be quite effective. This paper presents a Cognitive conceptualization of Borderline Personality Disorder, discusses the assessment and treatment of Borderline Personality Disorder within a Cognitive Therapy framework, and compares Cognitive Therapy of Borderline Personality Disorder with alternative treatment approaches. Particular emphasis is placed on the ways in which psychotherapy with Borderline individuals is different from psychotherapy with other persons and on the modifications in the Cognitive Therapy approach which are needed to take these characteristics into account.

Borderline Personality Disorder:
Too Complex for Cognitive Therapy?

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Borderline Personality Disorder is a form of psychopathology which is apparently common (American Psychiatric Association, 1980, p. 322), which often produces significant impairment, and which greatly complicates psychotherapy. However, it is a diagnostic category with which many clinicians have little familiarity and which has received very little attention from authors presenting cognitive-behavioral approaches to psychotherapy. The bulk of the literature on psychotherapy with Borderline Personality Disorder has been based on object-relations theory or other psychoanalytic approaches and it has been argued that psychoanalytic psychotherapy is the treatment of choice for borderline patients (Kernberg, 1977). Some have been quick to assume that cognitive and behavioral approaches are not capable of dealing effectively with this type of complex, long-standing problem. However, clinical experience suggests that, when properly applied, Cognitive Therapy can be effective with Borderline Personality Disorder and may have some distinct advantages over alternative treatment approaches.

Clinical Assessment

The term "borderline" has been used in a variety of ways during its short career as a diagnostic category. It was originally used to refer to patients who presented both "neurotic" and "psychotic" types of symptoms and who were thus seen as falling on the "borderline" between neurotic and psychotic. In common usage this term often meant "nearly psychotic" or "somewhat psychotic" and it was not unusual to hear some professionals talk of borderline patients who had "gone south of the border" when referring to patients who would be more appropriately diagnosed as experiencing a Brief Reactive Psychosis.

With the rise of object-relations theory many authors began to use the term borderline to refer to a particular type of personality organization rather than as a diagnostic category per se (e.g., Kernberg, 1975). With this usage of "borderline" an individual could be considered borderline whether or not a mixture of neurotic and psychotic symptoms was present at the moment, and an individual presenting this mixture of symptoms would not be considered borderline if his or her personality organization did not correspond to the expected pattern.

Finally, as with many other poorly understood diagnostic categories, the term borderline was often used simply to refer to individuals who didn't quite fit the other diagnostic categories. This often resulted in "borderline" being used to refer to a heterogenous group of individuals who differed in significant ways. For example, when Grinker, Werble, and Drye (1968) performed a cluster analysis on data from 51 patients labeled "borderline" they found four distinct sub-groups rather than one group of individuals sharing a

core of common characteristics.

Given this mixture of conflicting and overlapping meanings for "borderline" it is not surprising that some of the authors of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III, American Psychiatric Association, 1980) argued that it would be best to drop the term borderline and choose a new label (Millon, 1981, pp.331-335). However, rather than inventing a new diagnostic label, DSM III provides a new definition of "borderline" in its diagnostic criteria for Borderline Personality Disorder. The DSM III criteria clearly identify a group of individuals who manifest many of the features previously discussed under the label "borderline" and who share many important characteristics. When the term borderline is used in this discussion it will refer to Borderline Personality Disorder as defined in DSM III unless otherwise noted. Thus, in comparing this discussion with other discussions of psychotherapy with "borderline" patients it will be important to remember that other authors may be referring to somewhat different groups of patients.

The authors of DSM III use the term "personality disorder" to refer to "enduring patterns of perceiving, relating to, and thinking about the environment and oneself" which are characteristic of a person's long-term functioning and which are sufficiently inflexible and maladaptive to cause significant impairment or subjective distress (APA, 1980, p. 305). Borderline Personality Disorder is defined (APA, 1980, pp. 321-323) as a personality disorder in which there is instability in a variety of areas including interpersonal behavior, mood, and self-image. Since no single feature is invariably present and since variability is one of the hallmarks of Borderline Personality Disorder, assessment and diagnosis is more complex than

with some of the other diagnostic categories. Diagnosis is based on the presence of at least five of eight categories of problems (shown in Table 1) as a part of the individual's long term functioning, not simply their presence during a period of acute disturbance.

Table 1 about here

In a recent empirical study of diagnostic criteria for Borderline Personality Disorder, Clarkin, Widiger, Frances, Hurt, and Gilmore (1983) examined the diagnostic efficiency of each criterion. They found that when the symptoms of identity disturbance and unstable/intense relationships were both present or when impulsivity, unstable/intense relationships, and intense/uncontrolled anger appeared together the probability of the individual meeting diagnostic criteria for Borderline Personality Disorder was quite high. They also found that these two patterns were characteristic of at least 80% of their borderline sample.

Clinically the most striking features of borderlines are the intensity of their reactions, their changeability, and the great variety of symptoms they present. They may abruptly shift from a pervasive depressed mood to anxious agitation or intense anger, may impulsively engage in actions which they later recognize as irrational and counterproductive, and may present a problem with obsessive ruminations in one therapy session, depression in the next session, and a specific phobia in a third session. They typically present an erratic, inconsistent, unpredictable pattern of problems which can include their functioning effectively and competently in some areas of life while encountering dramatic problems in other areas. For example:

A young woman who I saw early in my training was doing quite well as a social work intern in a residential setting for disturbed adolescents and was making better progress on her masters thesis than I was on mine. However, at the end of the day she would lapse into an immobilizing depression and struggle with impulses to slash herself with broken glass. She reported a long history of excellent academic and vocational performance coexisting with severe problems in her personal life.

Individuals with Borderline Personality Disorder aren't necessarily in constant turmoil and may experience extended periods of stability, but they typically seek therapy at times of crisis and present a complex and somewhat chaotic clinical picture.

The lack of a stable pattern of typical symptoms makes diagnosing Borderline Personality Disorder complex and the task is further complicated by the fact that borderline individuals often present other disorders as well. Millon (1981) reports that borderline patients often manifest Generalized Anxiety Disorder, Panic Disorder, Obsessive Compulsive Disorder, Somatoform Disorders, Psychogenic Fugue states, Major Depression, Bipolar Disorder, Schizoaffective Disorder, Brief Reactive Psychosis, or additional personality disorders. Clarkin et al. (1983) found that even when consensus of three raters on the presence or absence of each of the DSM III criteria was required for diagnosis, 60% of their borderline sample met the criteria for other personality disorders as well. These diagnoses included Paranoid, Schizotypal, Histrionic, Narcissistic, Avoidant, and Dependent personality disorders.

The DSM III diagnostic criteria are sufficiently clear to permit reliable diagnosis if the clinician considers a diagnosis of Borderline Personality Disorder and obtains the necessary information. For many clinicians the primary difficulty lies in recognizing indications that it might be appropriate to consider a diagnosis of

Borderline Personality Disorder. Table 2 lists a number of characteristics which often serve as indications of Borderline Personality disorder. These are not intended as additional diagnostic criteria but may be useful in reminding the clinician to consider the possibility that these problems may be clues suggesting an undiagnosed personality disorder.

Table 2 about here

A clinical example may illustrate the complexities involved in correctly diagnosing Borderline Personality Disorder:

Mary, a 30 year old mother of two, requested treatment for chronic problems with depression, anxiety, isolation, and alienation. She said that she had been depressed her whole life but had first realized that she was depressed about ten years previously. During the period following her realization that she was depressed she had sought treatment from five different therapists but had not been helped by psychoanalytic psychotherapy and was frightened of psychotropic medication. As a part of the intake procedure she was asked to complete the Beck Depression Inventory, the Beck Anxiety Checklist, and the Minnesota Multiphasic Personality Inventory. Her responses indicated that she was severely depressed, that she experienced frequent periods of intense anxiety, and that she was uncomfortable in social situations. The psychological testing results alone indicated that she was likely to have a strongly negative self image, unrealistically high standards for herself, and difficulty expressing anger or acting assertively, and suggested a diagnosis of Major Depression.

In the initial therapy session we discussed her goals and priorities and between the first and second sessions she developed the list of goals and priorities shown in Table 3. This list reveals several types of anxiety disorder (Agoraphobia, possible Social Phobia, possible Obsessive Compulsive Disorder) as well as difficulty trusting others, low stress tolerance, difficulty handling anger adaptively, and confusion over her sexual orientation. In the second session she reported serious suicidal impulses resulting from a complex marital conflict. In the third session she was extremely confused over whether to leave her husband whether to return to her previous therapist and whether to ask for medication and was pleading for someone to take care of her. Within two months these issues had largely been resolved and she had developed a Panic Disorder focused on a planned trip to Jamaica.

Table 3 about here

While Mary's intake interview and her MMPI scores suggested a diagnosis of Major Depression, it was clear within the first few sessions that she also manifested many features of Borderline Personality Disorder. She presented a wide range of problems, had difficulty choosing her goals, and her goals and problems varied from week to week. Her emotional reactions were intense, changeable, and tended to switch from one extreme to another. She described a very difficult childhood, periods of poorly planned impulsive behavior, and an apparently psychotic period following drug use. She had a long history of uneven performance and continued to do well in graduate school despite periods of personal and marital crisis.

It is common for symptoms of a Borderline Personality Disorder to become apparent only gradually. In a problem focused therapy approach such as Cognitive Therapy, such a personality disorder may go unrecognized for an extended period of time since the individual's relationship history, his or her characteristic ways of handling anger, or the degree to which he or she has a clear sense of identity may not be discussed unless they are clearly related to the treatment goals. Mary was unusual in that her intelligence, verbal fluency, and insights gained through years of psychoanalytic therapy allowed her to present the salient issues much more clearly and concisely than is usually the case.

Conceptualization

The most widely known conceptualizations of Borderline Personality Disorder have been based on object-relations theory or other contemporary psychoanalytic approaches. Unfortunately, the terminology used in these analyses is largely incomprehensible to clinicians who do not share this theoretical orientation and the resulting theories are largely untestable. Otto Kernberg, a leading proponent of object-relations theories of Borderline Personality Disorder summarizes his point of view as follows:

"The main structural characteristic of borderline patients ... is the presence of persistent patterns of behavior and intrapsychic functioning which reflect the dissociation of contradictory, potentially severely conflictual and anxiety-raising object relations. These object relations are primitive, fantastic, and unrealistic in nature, and these characteristics become manifest as the internal object relations are re-enacted with the therapist in the transference. What becomes crucial is the extent to which the patient presents himself as an integrated or dissociated self in the transference, the extent to which his major object representations are integrated (total) or dissociated (part objects), and the extent to which projection of self- and object images in rapid succession and alternation brings about chaos, meaninglessness, or a generally fantastic quality to the transference. ... the diagnosis, interpretation, and resolution of primitive transferences reflecting primitive internalized object relations are major technical requirements in the treatment of borderline patients." (Kernberg, 1977)

The core of the object-relations view appears to be the assertion that, because of childhood experiences, the borderline individual holds extreme, poorly integrated views of relationships with care-givers and, as a result, holds extreme, unrealistic expectancies regarding interpersonal relationships. These expectancies are seen as shaping both behavior and emotional responses. It is assumed that the most appropriate way to resolve this situation is to conduct therapy

in such a way that these expectancies will be manifested in an intensely emotional relationship with the therapist where they may be resolved through the application of psychoanalytic technique.

Millon (1981) provides a competing view based on Social Learning Theory in which he attributes a central role to the borderline individual's lack of a clear, consistent sense of his or her own identity. He argues that this lack of a clear sense of identity includes a lack of clear, consistent goals and results in poorly coordinated actions, poorly controlled impulses, and a lack of consistent accomplishment. In addition, he suggests that as a result of unstable or unsure identities borderlines become dependent on others for protection and reassurance and become vulnerable to separation from these sources of support. He asserts that this situation is complicated by intense conflicts regarding dependency and assertion and by their realization that their anger over being trapped by dependency could result in their losing the security they gain from dependency.

While these two theoretical approaches focus on aspects of the borderline experience which are widely considered to be important, little attention has been paid to the cognitive aspects of Borderline Personality Disorder. When the basic assumptions, beliefs, and expectancies of borderline patients are examined in Cognitive Therapy, striking patterns emerge which seem to explain many aspects of the behavior and emotional reactions of borderlines.

In Cognitive Therapy, one of the major interventions is to have patients record their thoughts and feelings during problem situations so that the beliefs and expectancies reflected in their thoughts can be examined during therapy sessions. In Table 4 you see a "thought

sheet" recorded by Mary, the depressed mother of two discussed above. At this point in therapy her depression had subsided substantially but she had developed a panic disorder in response to a planned vacation in Jamaica. It can be seen that a detailed understanding of her thoughts while anticipating the trip provides a simple explanation of this apparently strange problem. She was anticipating recurrent, inescapable panic attacks and not anticipating a relaxing vacation as most of us would assume. Examination of the cognitions recorded by borderline patients in the course of Cognitive Therapy appears to reveal the same processes observed in other individuals (Beck, 1976) and often provides simple explanations for unusual problems.

Table 4 about here

Over the course of Cognitive Therapy a substantial list of specific thoughts occurring in specific situations is accumulated, and often a pattern emerges which reveals a limited number of basic assumptions underlying many beliefs and expectancies. In Mary's case, as with most other borderline patients, three key basic assumptions were revealed: "The world is a dangerous and malevolent place", "I am relatively powerless and vulnerable", and "I am flawed or inherently unacceptable in some way".

Viewing the world as a dangerous place in which one is relatively powerless has important consequences. It leads directly to the conclusion that it is extremely dangerous to relax vigilance, to take risks, to reveal one's weakness, to be "out of control", to be in a situation where one cannot escape easily, etc. Each situation may be seen as a potential life-or-death situation with chronic tension and

anxiety disorders as the result.

Some persons who view the world as a dangerous place feel able to to rely on their own strengths and abilities in dealing with it (and develop a paranoid pattern) but the borderline's belief that he or she is relatively weak and powerless blocks this alternative. Other persons who see themselves as incapable of dealing effectively with the risks presented by daily life are able to resolve this dilemma by becoming dependent on someone who they see as capable of taking care of them (and develop a dependent or agoraphobic pattern), but the borderline's belief that they are inherently unacceptable leads to the conclusion that dependence entails a serious risk of rejection, abandonment, or attack. The borderline individual therefore faces quite a dilemma, convinced that he or she is relatively helpless in a hostile world with no easy source of security.

This difficult situation is complicated by an important aspect of the borderline's thought processes. As Beck (1976, Beck, et al., 1979) has documented, individuals may experience errors in thinking or "cognitive distortions" which predispose them to unrealistic evaluations of situations. Borderline individuals can, of course, experience the full range of cognitive distortions but one particular distortion which Beck refers to as "dichotomous thinking" has a pervasive effect on the borderline's functioning. Dichotomous thinking is the tendency to evaluate experiences in terms of mutually exclusive categories (such as: good or bad, flawless or defective, love or hate) rather than categorizing experiences along continua. The end result of this "black or white" thinking is to force extreme interpretations on relatively neutral events. There is no neutral category, simply a choice between two extreme categorizations. If it is true that an

individual's evaluation of a situation plays an important role in determining his or her emotional and behavioral responses then dichotomous thinking would lead an individual to experience intense emotional responses and extreme behavioral responses. Dichotomous thinking would also lead to abrupt shifts in mood and behavior because the absence of neutral categories means that when the individual's perception of a situation changes, it necessarily changes from one extreme to another. In dichotomous thinking a person who does not prove absolutely and completely trustworthy is seen as completely untrustworthy and it is not possible to conceive of a person who is trustworthy most of the time.

It is dichotomous thinking coupled with the borderline's basic assumptions which transforms the world from a place which presents some risks and threats to a life-and-death situation, which transforms the borderline from a person with some faults and shortcomings to someone who is inherently unacceptable, and which exaggerates each of the conclusions the individual reaches. For instance, the borderline's strong desire for closeness, nurturance, dependance, and security conflicts with his or her world-view and self-concept and this combined with dichotomous thinking leads easily to the conclusion "I'll never get what I want, everything else is pointless" and to depression.

The dichotomous thinking creates and perpetuates some of the borderline's conflicts. For example; frustration (or anticipated frustration) of the borderline's desire for closeness and dependency often leads to intense anger which is seen by the borderline as being so devastating that it would destroy any chance of a close relationship if expressed. However, satisfaction of the desire for

closeness and dependency is seen as being intolerably dangerous because in a hostile world to be dependent is to be helpless and vulnerable. This intense conflict over dependency and anger would vanish if it were possible for the borderline to take a more moderate view and say "It would be good to be diplomatic in expressing my dissatisfactions so that this doesn't cause additional problems" and "Depending on someone opens me to the possibility of being hurt or disappointed so I should try to use good judgement about who to depend on and how dependent to be". However, borderlines seem to have great difficulty shifting from dichotomous thinking to thinking in terms of continua without help.

The final component which seems to play a central role is the borderline's weak or unstable sense of his or her own identity. Confusion regarding goals and priorities makes it difficult to work consistently and effectively towards long-term goals, especially in the face of abrupt emotional shifts. A low sense of self-efficacy leads to low motivation and low persistence. A lack of a clear sense of self makes it difficult for them to provide their own structure in ambiguous situations and also makes it difficult for them to maintain a clear sense of themselves as separate from the other person in an intimate relationship.

The basic assumptions, dichotomous thinking, and weak sense of identity do not simply each contribute separately to Borderline Personality Disorder. They form a mutually reinforcing and self-perpetuating system which is yet to be fully untangled. For example, there is reason to believe that viewing the current situation as dangerous encourages dichotomous thinking, dichotomous thinking encourages the idea that one is inadequate, and the belief that one is

inadequate supports the idea that the situation is dangerous. Similarly, viewing the situation as dangerous discourages risk-taking, avoidance of risk-taking deprives the individual of the experiences which could serve as a basis for a positive sense of self-efficacy, and a low sense of self-efficacy supports the idea that risk-taking should be avoided. The complexity of the resulting pattern can be seen easily when an attempt is made to present it graphically as in Table 5.

Table 5 about here

Strategies For Intervention

The usual approach in Cognitive Therapy is to quickly establish a collaborative working relationship, select clear goals and priorities, and form an initial conceptualization which serves as a foundation for subsequent interventions. The therapist then uses a "guided discovery" approach which relies strongly on the client's monitoring his or her thoughts and feelings in problem situations. Gradually the client is helped to look critically at his or her responses in problem situations and to evaluate the accuracy of cognitive responses by testing them against previous experiences or testing them through behavioral experiments. The client is then taught how to replace unrealistic thoughts with more accurate views of the situation and is guided in developing effective responses to those situations which remain problematic when viewed realistically. Cognitive Therapy generally includes an examination of the assumptions underlying

unrealistic evaluations of situations and ends with a focus on preparing the individual to deal effectively with future problems. This approach provides an efficiently structured therapy which is tailored to the client's particular needs.

A number of the features of Borderline Personality Disorder create definite problems in Cognitive Therapy with borderline patients. Establishing a collaborative working relationship requires some degree of trust and intimacy; however, trust and intimacy are major issues for most borderline individuals. Strategic, problem focused psychotherapeutic approaches such as Cognitive Therapy and most other cognitive-behavioral therapies require the therapist and patient to agree on specific goals and maintain a consistent focus on specific goals; however, many borderline individuals have great difficulty determining what their goals are and their priorities often shift from week to week. Cognitive-behavioral therapists are generally accustomed to establishing rather straightforward, businesslike relationships with their patients which minimize transference and other interpersonal complications; however, therapy with borderline individuals necessarily involves working with intense emotional interactions within the therapy session. Cognitive Therapists are oriented towards helping clients change quickly and efficiently, but borderline individuals often fear change and resist sudden changes. Cognitive Therapy is often seen as a short-term therapy, but borderline individuals often need much more than 10 or 20 weeks of treatment. Therapists who attempt to work with borderline individuals without taking these features into account run the risk of providing an ineffective treatment, having the patient terminate therapy prematurely, or precipitating a serious crisis.

In working with borderline patients it is particularly important to maintain a collaborative, strategic approach based on guided discovery rather than theoretical preconceptions. With Cognitive Therapy's wealth of specific techniques designed to address specific problems it is easy to slip into a "cookbook" approach where the therapist starts to think in terms of matching techniques to problems rather than basing interventions on a conceptualization of this individual patient. While this approach may work adequately in many situations it can lead to significant problems when working with a "non-standard" problem and borderline patients often have idiosyncratic cognitions underlying apparently commonplace problems. In addition, with the large number of diverse problems which borderline patients often present it is important to focus on the problems which are central for this particular individual and a "cookbook" approach provides few guidelines for choosing where to intervene. When the therapist adopts a guided discovery approach rather than a cookbook approach the therapist and the patient are constantly obtaining new data which alerts the therapist to any unusual patterns behind apparently ordinary symptoms and which provides the information needed for them to select key problems for intervention.

The interpersonal aspects of therapy are much more important with borderline patients than is usually the case in Cognitive Therapy. Often, in Cognitive Therapy with other patients, it is sufficient for the therapist to focus initially on establishing a good working relationship and then it is possible to focus on the patient's problems with little additional attention to the therapeutic relationship. However, many of the borderline patient's problems

involve interpersonal relationships and are manifested in the patient's relationship with his or her therapist just as they are in other relationships. In addition, the patient's strong emotional responses to the therapist, the complexity of the patient's problems, and the intensity of the patient's responses may elicit strong emotional responses in the therapist which can have an important impact on therapy.

Psychodynamic therapists spend much time discussing the phenomenon of transference, the patient's responding to the therapist on the basis of experiences in previous relationships rather than responding to the therapist's behavior. This is a phenomenon which rarely occurs in Cognitive Therapy with most patients but is much more likely in Cognitive Therapy with borderline patients. It can be quite problematic for therapists who are not used to dealing with strong emotional responses from their patients. For example:

A thirty-eight year-old medical technician consulted her physician regarding difficulties handling stress and he began providing biofeedback training. Treatment proceeded uneventfully until the patient suddenly began to experience a strong sexual attraction to her physician and decided she was in love with him. The physician decided he could not continue to work with her given these feelings so he had his secretary call the patient to tell her that he could no longer treat her but that his wife would be able to continue the biofeedback training. The patient became increasingly preoccupied with the physician, her behavior became increasingly inappropriate, and she was eventually hospitalized with a Brief Reactive Psychosis. A more thoughtful response on the physician's part might well have averted the psychotic reaction.

The phenomenon which psychoanalysts refer to as transference can be easily understood in cognitive terms. In interpersonal situations our responses are customarily a product both of the behavior of the other persons and of our beliefs and expectancies about interpersonal interactions. These beliefs and expectancies are based on our previous

experiences in interpersonal relationships. In an ambiguous interpersonal situation, such as psychanalytic psychotherapy, the individual's responses are necessarily based largely on his or her beliefs and expectancies because the other person's behavior is difficult to interpret. An active, directive therapeutic approach such as that used in Cognitive Therapy minimizes responses which are based primarily on experiences in previous relationships because the therapist takes a straightforward, unambiguous role. However, this does not completely eliminate these strongly emotional responses, particularly with patients such as borderlines who have very strong, extreme beliefs and expectancies and are vigilant for any indication that their hopes or fears may be realized. When such responses do occur it is essential to deal with them promptly and directly by first developing a clear understanding of what the patient is thinking and feeling and then clearing up the misconceptions and misunderstandings directly and explicitly. It is particularly important to make it clear to the patient that he or she will be neither exploited nor rejected.

Borderline patients are particularly likely to experience strong emotional reactions and potential crises at the termination of therapy, particularly if it is necessary for some reason to terminate therapy before treatment is completed. It is important for the therapist to initiate discussion of the patient's expectations, fears, and feelings well in advance of the termination date and to return to this discussion on several occasions even if the patient initially insists that termination is not a major concern. Clinical experience suggests that it is often advisable to initiate this process three months in advance of termination and that it is often helpful to taper treatment off gradually by moving from weekly appointments to

bi-weekly sessions then monthly sessions.

Therapists working with borderline patients are likely to discover that, from time to time, interactions with particular patients elicit strong emotional reactions ranging from empathic feelings of depression to strong anger, hopelessness, or attraction. It is important for the therapist to be aware of these responses and to look at them critically so that they do not unduely influence therapy. However, far from being an impediment, if the therapist is able to understand his or her emotional responses in therapy and is able to control them adequately they can be quite useful. Emotional responses do not occur randomly. If a therapist experiences an unusually strong response to a patient this is likely to be a response to some aspect of the patient's behavior and it may provide valuable information if it can be understood. It is not unusual for a therapist to respond emotionally to a pattern in the patient's behavior long before the pattern has been recognized intellectually and accurate interpretation of the emotional response can speed recognition of the pattern. However, judgement must be exercised in deciding whether to express these emotional reactions. Self-disclosure by the therapist increases the level of intimacy and may be threatening to the patient but denial of an emotional response which is apparent from non-verbal cues may decrease trust and encourage the patient's fears. Whenever a therapist is having difficulty understanding his or her responses to a patient or is uncertain about how to handle them it is important to seek consultation from an unbiased colleague.

Throughout therapy is is advisable for the therapist to strive for a calm, methodical approach and to resist the tendency to respond to each new symptom or crisis as an emergency. Many new symptoms and

crises will turn out to be transitory problems which vanish as quickly as they appeared. For those problems which do become the focus of therapy for a period of time it is important to evaluate the situation in detail before intervening rather than reflexively trying "standard" interventions which may be off the mark. In particular, if the borderline patient begins to manifest extreme agitation, signs of thought disorder, or other indications of a Brief Reactive Psychosis, a calm, measured response from the therapist may be sufficient to calm the patient and avert the psychotic episode. If it is not possible to prevent the psychosis from developing this need not be tragic. While a brief hospitalization may be necessary and psychotropic medication may be useful, these psychotic reactions rarely produce lasting effects as long as the patient and therapist do not decide that this is a sign of "craziness" and give up (American Psychiatric Association, 1980). While the symptoms manifested during a Brief Reactive Psychosis may resemble Schizophrenia, a duration of at least six months is required for the diagnosis of Schizophrenia while a Brief Reactive Psychosis often lasts only a few days.

Specific Cognitive-Behavioral Techniques

The first problem in Cognitive Therapy with borderline individuals is establishing a collaborative working relationship. With most patients this is done relatively quickly and easily. The borderline, however, has generally discovered through painful experience that it can be very dangerous to trust other people and quickly realizes that the therapist-patient relationship is a

relationship in which he or she will be very vulnerable at times. It rarely is productive to try to establish trust through persuasion, argument, or pointing to one's credentials. The borderline is not foolish enough to trust someone simply because they say they can be trusted or because they have a diploma. Trust is most effectively established through explicitly acknowledging and accepting the patient's difficulty in trusting the therapist once this becomes evident and then being careful to behave in a trustworthy manner in order to provide the evidence on which trust can be based. It is important to exercise more than the usual amount of care in communicating clearly, assertively, and honestly, avoiding misunderstandings, maintaining congruence between verbal statements and non-verbal cues, and following through on agreements. It is important not to press the patient to take risks in therapy until a sufficient level of trust has been established and it is important to make it clear that they have the option of not talking about sensitive topics until they feel ready to do so.

Crises, emergency telephone calls, and requests for special arrangements are common during the early stages of therapy with many borderline patients. Traditionally this behavior has been viewed as a "test" of the therapist's reliability and caring. While it is not clear that crises early in therapy are intentionally staged as tests of the therapist they often function as such and it is important for the therapist to handle emergency phone calls and requests for special treatment effectively if he or she wishes the patient to continue in treatment. However, it is not necessarily important for the therapist to agree to the patient's requests or encourage midnight telephone calls. It is important for the therapist to consider how far he or she

is willing to go in being responsive to the patient and for the therapist to then be responsive to the patient but to set clear, consistent limits. If the therapist is unresponsive, or is inconsistent in setting limits the patient is likely to become angry or terminate therapy abruptly; and if the therapist fails to set suitable limits and begins to resent the patient's demands this resentment is likely to interfere with therapy. It often works well to set a policy of keeping emergency telephone sessions brief and limiting them to crisis intervention, and then offering to schedule a therapy session as soon as possible as an alternative to lengthy phone contacts. Also, it is generally advisable for the therapist to make no special arrangements for one patient which the therapist would not be willing to extend to other patients. Most borderline patients adapt quickly to clear, consistent guidelines and if a patient is not willing or able to accept reasonable limits they are not likely to be able to benefit from the collaborative approach inherent in Cognitive Therapy.

Often a borderline individual's discomfort with intimacy will extend to some aspects of the therapy setting and subtle aspects of the interpersonal interaction may sometimes elicit intense anxiety in the patient. For example, after several weeks of therapy a patient hesitantly mentioned that several times in each session she would become intensely anxious for no apparent reason and would have to resist a strong desire to run from the room. As we explored this problem it gradually became clear that whenever I leaned forward in my chair and made direct eye contact this raised the level of intimacy higher than she could tolerate at that point. It may be necessary to limit the amount of direct eye contact, to increase the distance

between chairs, and to avoid handshakes, familiarity, or therapist self-disclosure early in therapy in order to avoid excessive discomfort which could impede therapy or lead to premature termination. It can be quite helpful to explicitly involve patients in this process by soliciting their feedback and making it clear that you will seriously consider any suggestions they have for making therapy more comfortable for them. The patient's realization that he or she has some control over the seating arrangement, the topics discussed, etc. in itself renders the intimacy of the therapeutic relationship less threatening by making it clear that the intimacy is not inescapable.

An initial focus on concrete behavioral goals can be very useful in reducing the impact of the borderline's difficulties with intimacy and trust. For most borderline individuals, working on problems where little introspection is required and where the focus is on their behavior rather than their thoughts and feelings is less threatening than focusing directly on the therapeutic relationship or on deeply personal problems. Yet this provides an opportunity to build trust and increase their tolerance for intimacy while making demonstrable progress towards their goals and thereby increasing their motivation for persisting with therapy.

When working with borderline patients there is a conflict between being responsive to the patient's immediate concerns and maintaining a focused strategic approach. If each session deals with a different issue as the patient's concerns and problems shift from week to week little will be accomplished; but if the therapist insists on sticking to a fixed set of goals and priorities the therapist has abandoned Cognitive Therapy's collaborative approach and in addition risk-

alienating the patient. It is particularly important to maintain a collaborative approach even if this means revising goals and priorities periodically. Cognitive Therapy with borderline individuals calls for greater flexibility than conventional Cognitive Therapy. It may be possible to maintain a consistent focus in therapy simply by discussing the pros and cons of maintaining a steady focus or by agreeing to set aside part of the session for current issues and then shifting to ongoing goals. However, with some patients it is necessary to focus on a different immediate crisis each week and to maintain continuity by addressing the issues underlying the immediate crisis. For example, problems such as failure to anticipate the consequences of one's actions or assuming that one is helpless and consequently responding passively to difficulties can be manifested in many different problem situations and it is possible to continue to use a focused approach while responding to a series of different but related problems if the therapist draws attention to the underlying issue while working on each specific problem.

Both the patient's belief that the world is a dangerous place and the patient's belief in his or her own helplessness can be gradually challenged through helping them to test their expectancies against their previous experience, developing behavioral experiments which can be used to test expectancies, and helping them to develop new competencies and coping skills. For example, when Mary developed her fear of vacationing in Jamaica which was presented in Table 4 it was possible initially to help her to examine her extensive experience with previous panic attacks and discover that the panic attacks were not likely to be continuous, that the attacks were not likely to ruin the whole trip, and that while the attacks were intensely unpleasant

they were not dangerous. Over the course of the next several sessions it was possible to help her to learn to cope more effectively with anxiety through attention focusing techniques, progressive relaxation training, and related techniques. In addition, it was possible to challenge some of the thoughts which contributed to her anxiety such as the belief that her husband would leave her if her anxiety ruined the vacation. When the time for the vacation arrived it was possible to use the vacation itself as a behavioral experiment by having her state her expectancies clearly before the trip and then comparing these expectancies with her actual experience when she returned. When she found that she was able to cope with intense anxiety well enough to prevent panic attacks, was able to have a very good time, and was able to cope effectively with unexpected problems which arose she began to look more skeptically at her belief that new challenges would always turn into disasters because of her incompetence.

Dichotomous thinking is often such a pervasive component of the borderline individual's cognitive functioning that it is difficult for him or her to conceive of thinking in terms of continuous dimensions rather than discrete categories. In order to work to reduce dichotomous thinking it is first necessary to demonstrate to the patient that he or she engages in dichotomous thinking by pointing out examples as they are discovered while monitoring the patient's responses in problem situations. It is then possible to help the patient to discover that thinking in terms of continua is more realistic than dichotomous thinking by choosing a relevant dimension, such as trustworthiness, and asking the patient to provide clear operational definitions for the two extremes. It is then possible to assign numerical values (0 & 10) to the two extremes and ask the

patient to rate various individuals they know on the resulting continuum. Patients often have a tendency to simply rate individuals at one extreme or the other of the continuum initially. However, having developed operational definitions of the extremes before beginning, it is then possible to gently challenge these ratings through comments such as: "Are you sure that your sister rates a 10? You said that to be totally trustworthy a person would need to always do exactly what they said they would and be completely predictable, but I think you've mentioned her not being home when she said she would a couple of times recently. Would that make her totally untrustworthy or somewhere in the middle?" Since it is unlikely that all of the patient's acquaintances truly fall at the extremes of any continuum it is often easy to demonstrate that a continuous view is more realistic and thus has significant advantages in figuring out how to deal with people and situations. With a little practice borderline patients can become skilled at challenging their own dichotomous thinking and the frequency of dichotomous thinking gradually declines.

This decrease in dichotomous thinking often results in a decrease in the frequency of sudden mood swings and a decrease in the intensity of emotional reactions as the patient evaluates problem situations in less extreme terms. However, the patient can attain greater control over his or her emotional responses through increasing his or her ability to look critically at his or her thoughts in problem situations, by developing alternative ways to respond to problem situations, and by learning adaptive ways to express emotional responses. While the techniques used in monitoring and challenging thoughts and developing active, assertive responses to problem situations with borderline patients are no different from those used

with other clinical groups (see Beck, et al., 1979) it is particularly important not to rush the borderline patient and to be alert for complications. For example, many borderline patients believe that if they express certain feelings, such as anger, this will lead to immediate rejection or attack. As a result they often attempt to suppress any expression of these emotions and are extremely reluctant to consider an active, assertive approach which might include expressing annoyance or mild levels of other problematic emotions. The therapeutic relationship may provide a situation where the patient can experiment with expressing these emotions in safety. The therapist can facilitate this by gently asking how the patient is feeling when situations occur which would produce annoyance, etc. in the average patient and making a point of explicitly acknowledging and accepting the emotional responses which the patient is willing to express. It is probably not a good idea for the therapist to stage situations in order to elicit feelings since the therapist's genuineness and honesty is important for maintaining a trusting working relationship.

Impulsive behavior can often be dealt with effectively by first helping the patient to explore the advantages and disadvantages of impulse control in order to ensure sufficient motivation and then examining the cognitions preceding impulsive behavior and using self-instructional training (Meichenbaum, 1977) if necessary. Self-destructive impulsive behavior can be particularly problematic since it may be necessary to eliminate this behavior quickly. First, it is important to develop a clear understanding of the motivation for self-destructive behavior by examining the thoughts leading up to the self-destructive impulses or behavior. It is then possible to ask the questions "What do you want to accomplish through this action?" and

"Is there another way to accomplish this which is likely to be more effective or have fewer bad side effects?". If it is possible to identify alternative responses which are more effective and less destructive than the problem behaviors, these can be substituted for the problem behaviors. As a stop-gap measure it is sometimes possible to substitute a minimally self-destructive behavior such as marking oneself with a marking pen for a more self-destructive act such as slashing oneself.

A clearer sense of one's own goals, priorities, competencies, and accomplishments is, to some extent, a side effect of choosing specific goals for therapy and working to adopt an active, assertive approach in dealing with problem situations. However, it is possible to further facilitate the patient's developing a clearer sense of his or her own identity by helping to identify his or her positive characteristics and accomplishments, by providing unambiguous feedback when he or she makes a good decision or deal effectively with a problem situation, and by responding openly and honestly to requests for feedback. It is generally wise to provide feedback in moderation and to avoid effusiveness since borderline patients may be very uncomfortable with positive feedback at first. It is important for feedback to be honest, since unrealistic positive feedback simply lowers the therapist's credibility.

Borderline patients are often quite sensitive to issues of control and in an active, directive therapy it is quite easy for therapist and patient to become locked in a power struggle over agenda setting or homework assignments. It is important to remember that it is very difficult for a patient to stage a power struggle if the therapist doesn't participate actively in it. If the therapist adheres

to the collaborative model underlying Cognitive Therapy and allows the patient to have a part in developing agendas and homework assignments, is responsive to their requests, and is careful to work with the patient power struggles are less likely. It is important to remember that there is no magic to one particular format for monitoring and challenging thoughts, learning to relax, etc. The therapist may need to use some flexibility in tailoring standard techniques to the individual patient's needs.

When problems with noncompliance do occur it is rarely productive for the therapist to take a parental role and simply insist that the patient do the assignments. Often it is much more productive to explicitly acknowledge that the patient has the power to refuse to do whatever they wish but then to explore with the patient what will be accomplished if the patient chooses not to do homework and what will be accomplished if they choose to do it. If the rationale behind the assignment is clear and the patients recognize that they are choosing to do it, not being forced to do it, then there is much less chance of problems with non-compliance.

One factor which often contributes to problems with non-compliance and which can also produce increased distress during therapy or lead to premature termination is fear of change. If it is true that borderlines typically assume that the world is a dangerous place and often have a low tolerance for ambiguity, then it would not be surprising if they feared change. When persons are in a dangerous situation (or one which they view as dangerous) they have a tendency to rely on their usual coping responses because they realize that trying novel solutions involves taking a risk and increases their uncertainty about the outcome. The borderline patient's usual coping

responses may be quite unsatisfactory but at least they are familiar and the outcomes are predictable. Trying new responses involves taking a step into the unknown.

The borderline patient's fear of change can be reduced to some extent by addressing it openly when it becomes apparent and by examining the risks involved in trying new responses in this particular situation. However, it is generally necessary to make a point of making changes in a series of small steps and to be careful not to press for change too quickly. Therapists often experience a desire to "go for the kill" when they see an opportunity to make a dramatic intervention which could produce a sudden change; however, with borderline patients it is generally better to err on the side of caution. It is much easier to work with a patient who sees gradual change and is eager to continue than it is to work with a patient who is terrified by sudden changes and is reluctant to continue therapy. Patients can be valuable guides in pacing therapy if the therapist solicits their feedback and is attentive to signs of increased distress or reluctance.

Fear of change can be intensified by the patient's assuming that therapy will end as soon as the problems are overcome and fearing an abrupt abandonment by the therapist. When such fears are present it is important to make it clear to the patient that therapy will not be terminated abruptly because they have improved but that termination of therapy will be a joint decision.

Conclusion

To date no empirical research has been done either on the cognitions of borderline individuals or on the outcome of Cognitive

Therapy with borderline patients. It goes without saying that such research is needed and that it will not be possible to adequately test the theoretical analysis and treatment approach here until such data has been collected. However, the experiences of a number of clinicians who have used Cognitive Therapy with borderline patients suggests that Cognitive Therapy can be quite effective if skillfully applied.

Working with borderline patients is more complex than working with patients with isolated problems with depression or anxiety and takes longer. However, it is often possible to not only alleviate patients' anxiety or depression but also help them to gradually resolve long-standing problems such as identity confusion and inability to maintain stable intimate relationships. Since no followup studies have been done, we can't be certain that these improvements persist. However, patients maintain these improvements over a gradual "tapering-off" period at the close of therapy and it seems likely that patients who receive adequate preparation for dealing with future problems would be able to maintain the improvements achieved in therapy.

It appears that Cognitive Therapy may have significant advantages over the leading treatment alternative, psychoanalytic psychotherapy. First, since psychoanalytic psychotherapy for Borderline Personality Disorder is a transference-based treatment which does not focus on treating specific symptoms (Kernberg, 1977b), Cognitive Therapy typically produces improvement in important symptoms much more quickly. Second, psychoanalytic authorities on the treatment of Borderline Personality Disorder report that therapy typically requires five to seven years (Masterson, 1982) while Cognitive Therapists more commonly report completing treatment in one and one-half to two and

one-half years.

While much work remains to be done, it is rapidly becoming clear that Cognitive Therapy can be effective with many problems other than depression. With continued clinical exploration and much additional research it should be possible to provide better treatment in many areas.

REFERENCES

- American Psychiatric Association Diagnostic and statistical manual of mental disorders, Third Edition. The American Psychiatric Association, 1980.
- Beck, A.T. Cognitive therapy and the emotional disorders. New York: International Universities Press, 1976.
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. Cognitive therapy of depression. New York: Guilford, 1979.
- Clarkin, J.F., Widiger, T.A., Frances, A., Hurt, S.W., & Gilmore, M. Prototypic typology and the borderline personality disorder, Journal of Abnormal Psychology, 1983, 93, pp. 263-275.
- Grinker, R.R., Werble, B., & Drye, R.C. The borderline syndrome. New York: Basic Books, 1968.
- Kernberg, O.F. Borderline conditions and pathological narcissism. New York: Jason Aronson, 1975.
- Kernberg, O.F. Structural change and its impediments. In: Hartocollis, P. (Ed.) Borderline personality disorders: The concept, the syndrome, the patient. New York: International Universities Press, 1977.
- Masterson, J.F. Borderline and narcissistic disorders: An integrated developmental approach. Workshop presented at Adelphi University, Garden City, New York on April 17, 1982.
- Michenbaum, D. Cognitive-behavior modification: An integrative approach. New York: Plenum, 1977.
- Millon, T. Disorders of personality DSM III: Axis II. New York: Wiley, 1981.

Table 1

Diagnostic Criteria for
Borderline Personality Disorder

At least 5 of the following are characteristic of the individual's current and long-term functioning and are not limited to episodes of illness:

- (1) Impulsivity or unpredictability in at least two areas that are potentially self-damaging, e.g., spending, sex, gambling, substance use, shoplifting, overeating, physically self-damaging acts
- (2) A pattern of unstable and intense interpersonal relationships, e.g., marked shifts of attitude, idealization, devaluation, manipulation (consistently using others for one's own ends)
- (3) Inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger
- (4) Identity disturbance manifested by uncertainty about several issues related to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values, and loyalties, e.g., "Who am I?", "I feel like my sister when I am good"
- (5) Affective instability: marked shifts from normal mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days, with a return to normal mood
- (6) Intolerance of being alone, e.g., frantic efforts to avoid being alone, depressed when alone
- (7) Physically self-damaging acts, e.g., suicidal gestures, self-mutilation, recurrent accidents or physical fights
- (8) Chronic feelings of emptiness or boredom

If under 18, does not meet criteria for Identity Disorder.

note: Co-occurrence of 1,2, & 3 or 2 & 4 appear to be highly predictive of Borderline Personality Disorder (Clarkin et al., 1983)

Table 2

Possible Indications of
Borderline Personality Disorder

In Presenting Problems and Symptoms

1. a diverse assortment of problems and symptoms which may shift from week to week
2. unusual symptoms or unusual combinations of symptoms
3. intense emotional reactions which are out of proportion to the situation
4. self-punitive or self-destructive behavior
5. impulsive, poorly planned behavior which is later recognized as foolish, "crazy", or counterproductive
6. brief periods of psychotic symptoms which meet DSM III criteria for Brief Reactive Psychosis (but which may have been mis-diagnosed as schizophrenia)
7. Confusion regarding goals, priorities, feelings, sexual orientation, etc.
8. feelings of emptiness or void, possibly localized in the solar plexus

In Interpersonal Relationships

1. lack of stable intimate relationships (possibly masked by stable non-intimate relationships or relationships which are stable as long as full intimacy is not possible)
2. tendency to either idealize or denigrate others, perhaps switching abruptly from idealization to denigration
3. a tendency to confuse sexuality and intimacy

In Therapy

1. frequent crises, frequent telephone calls to the therapist, or demands for special treatment in scheduling sessions, making financial arrangements, etc.
2. Extreme or frequent misinterpretations of therapist's statements, intentions, or feelings
3. unusually strong reactions to changes in appointment time, room changes, vacations, or termination of therapy
4. low tolerance for direct eye contact, physical contact, or close proximity
5. unusually strong ambivalence on many issues
6. fear of change or unusually strong resistance to change

In Psychological Testing

1. Good performance on structured tests such as the WAIS combined with poor performance or indications of thought disorder on projective tests (especially the Holtzman Inkblot Test)
2. Elevation of both "neurotic" and "psychotic" MMPI scales

Table 3

Problem/Goal List

(in order of priority)

- (A1) The anxiety symptoms are driving me nuts. I want them gone before the problems have been solved!
- (1) I feel my mental/emotional problems are so severe they will never be resolved ... I fear + believe I'm beyond help.
 - (2) There's nobody I trust completely to help me if I'm ever unable to help myself ... this causes me terrible anxiety and hostility.
 - (3) I'd like to feel less isolated, alienated, alone + unique ...
 - (4) I'm very ambivalent about having a third child ... I'd like to resolve this dilemma once + for all.
 - (5) I'm terrified of the idea of being "out of control". I'd like to be able to ... risk lessening control.
 - (6) I suffer from agoraphobic symptoms at times ... I'd like ... to put an end to them.
 - (7) I want to be able to display hurt and anger better instead of withdrawing into a shell. The only people in the world to whom I can express affection freely ... are my children. I'd like to feel more comfortable being demonstrative ...
 - (8) I want to find better ways of dealing with my negative feelings about my mother ...
 - (9) I feel the majority of my life's energies + talents are going to waste because I spend so much time worrying ...
 - (10) I'd like to examine my "God/shit" complex - sometimes feeling superior to others, other times feeling so inferior ...
 - (11) ... the more I respect, admire, or care about a particular couple the more anxious I get going out socially with them ...
 - (12) I'm really obsessive/compulsive. As soon as one obsession disappears, I must immediately have something else to obsess about.
 - (13) I have this nagging fear that something awful will happen to one of my children.
 - (14) I want to define what I can realistically expect of myself as a parent + become comfortable with that.
 - (15) I worry, if I begin to feel close to another female, that my feelings could be sexual.
 - (16) I'm so perfectionistic that I'm perpetually frustrated, disappointed, or afraid to risk failure. But I'm also afraid of success beyond a certain point.
 - (17) I become overwhelmed by tight, demanding schedules - getting almost unbearably hyper.

Table 4

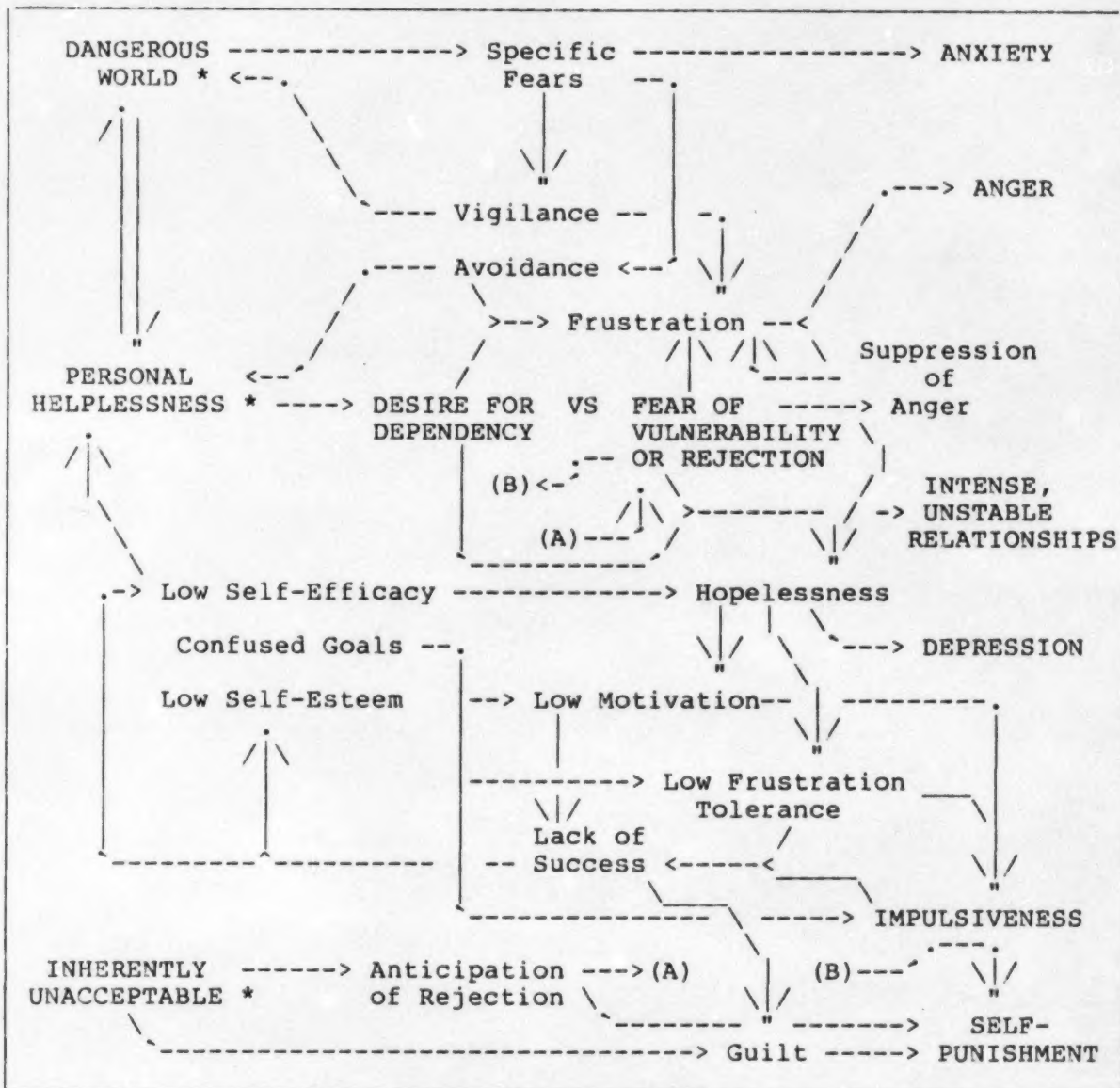
DAILY RECORD OF DYSFUNCTIONAL THOUGHTS

Situation	Emotion(s) (rate 1-100% *)	Automatic Thoughts (rate belief 0-100%)
Thinking about trip to Jamaica	Scared 100%	It will be just like it always is; I'll spend all the time till we go away being afraid of "freaking out" when we actually go, my fears will become a self-fulfilling prophecy, + I'll ruin the vacation for both of us. 100%
	Anxious 100%	
	Guilty 100%	
	Pessimistic 75%	I'm scared to death of the incapacitating, ail-consuming panic attacks I've always had before on vacations. I want to avert them, but I don't think I'll be able to. 100%
	Inadequate 75%	
	Hopeless 95%	
		I'm tired of being an emotional cripple, but I don't think I'll ever be better. 100%
		I feel so guilty about going away - first because <u>we</u> can have this vacation, + others can't; second, because I'm going someplace other than to visit my parents . 100%

* 1 = a trace, 100 = the most intense possible

Table 5

Tentative Model of Borderline Personality



* Hypothesized basic assumptions